AT RISK FOR UNDERWEIGHT (INFANTS, CHILDREN) (103A)
UNDERWEIGHT (INFANTS, CHILDREN) (103B)

PARTICIPANT TYPE……..**INFANTS, CHILDREN**
HIGH RISK……..**NO**

RISK DESCRIPTION:

DEFINITION OF AT RISK FOR UNDERWEIGHT:

- Birth to 2 years: > 2.3rd and ≤ 5th percentile weight-for-length
- 2-5 years: > 5th and ≤ 10th percentile Body Mass Index (BMI)-for-age

DEFINITION OF UNDERWEIGHT:

- Birth to 2 years: ≤ 2.3rd percentile weight-for-length
- 2-5 years: ≤ 5th percentile Body Mass Index (BMI)-for-age

Notes: For children birth to 2 years of age, these risks are based on the 2006 World Health Organization international growth standards. For children 2-5 years of age, these risks are based on the 2000 National Center for Health Statistics/Centers for Disease Control and Prevention age and sex specific growth charts.

ASK ABOUT:

- Birth status including birth weight and prematurity
- Growth history (especially if the WIC record has limited information about previous measurements); parental physiques
- Chronic medical conditions that affect metabolic needs and ability to consume an adequate diet including conditions that:
  - Increase metabolic needs (e.g., cystic fibrosis, anemia, lead poisoning, congenital heart disease, chronic renal insufficiency, recurrent respiratory infections, bronchopulmonary dysplasia, HIV/AIDS)
  - Make adequate intake difficult due to oral-motor dysfunction **(**e.g., cleft palate, esophageal strictures, pyloric stenosis, central nervous system dysfunction, gastroesophageal reflux, dysfunctional eating skills, hypersensitivity and oral aversion)
  - Result in increased gastrointestinal losses (e.g., cystic fibrosis, short gut, malabsorption, chronic diarrhea, inflammatory bowel disease, food allergy)
  - Alter metabolic needs (e.g., inborn errors of protein, carbohydrate, or fat metabolism)
  - Are associated with poor growth (e.g., Fetal Alcohol Syndrome)
- Special diets and medications used to treat identified medical conditions

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ASK ABOUT (CON'T):

- Recent or recurrent illnesses affecting nutritional status
- Developmental feeding skills in relationship to age
- Access to ongoing health care and attendance at well child visits
- Oral health status and ability to eat age-appropriate foods
- Family, religious or cultural issues affecting child feeding practices
- Typical intake pattern
- Parent and caregiver's knowledge about child nutrition, normal toddler and preschool feeding behaviors, hunger cues, and the division of responsibility in feeding
- Feeding problems and the parent's coping strategies (i.e., is the parent overly permissive or overly restrictive?)
- Family and household environment including the social and psychological environment (e.g., chaotic, highly distractible, disorganized), depressed parents or caregivers, number of caregivers, parental substance use or abuse
- Food security status of the household

NUTRITION COUNSELING/EDUCATION TOPICS:

- Consider the overall growth pattern before framing your messages. Children growing at or below 10th percentile may be at nutrition risk and should still be monitored. Many, but not all children growing at or below the 5th percentile for weight are in need of nutrition intervention. Reassure the parents that WIC will continue to monitor the child's growth.
- If the diet is overly restricted in calories or fat, explain the relationship between good nutrition and normal growth and development. Describe typical appetite patterns, growth patterns, and eating behaviors for infants and young children.
- Review relevant, age-appropriate feeding guidelines including:
  - Frequency of feedings (breastfeeding and formula)
  - Proper formula dilution
  - Introduction of solid foods when developmentally ready
  - Parent's awareness of hunger and satiety cues
  - Adequate number of servings from each food group and age-appropriate servings
  - Strategies to increase the caloric density of the diet including adding nuts, dried fruit, dry milk powder, grated cheese and other ingredients
  - Regular meals and snacks
  - The division of responsibility in feeding - Encourage the parent to allow the child to decide how much to eat.
  - Ways to foster a pleasant mealtime environment and limit distractions

POSSIBLE REFERRALS:

- If weight and length/height measurements continue to move downward on the growth chart, refer to the child's primary health care provider.
- If the child is not receiving well child care or keeping appointments, refer the child (if on medical assistance) to Health Tracks (http://www.nd.gov/dhs/services/medicalserv/health-tracks/), the local public health department, or primary care providers in the community.
- If access to sufficient food is a concern, refer to other food assistance programs such as SNAP, local food pantry, etc.
- If oral health status is affecting the child's ability to consume an adequate diet, refer to a local dental office, the local public health department (public health hygienists) or Health Tracks (if on medical assistance) for additional screening and referral. More information about oral health services in ND can be found at http://www.ndhealth.gov/oralhealth/.
- If the household and family situation is so disordered that establishing a normal feeding relationship is unlikely, refer the family to local public health department, a feeding team that works with children, or social service agency.
- If parental substance use or abuse is a concern, refer to community resources and treatment centers.
- If the child appears to have developmental delays, refer the family to the Right Track Program for early intervention services (http://www.nd.gov/dhs/services/disabilities/earlyintervention/parent-info/right-track.html).